

groups of muscles. With a view to confirming or confuting the conclusions arrived at above, in reference to the mode in which their atrophy is produced. (6) An investigation of the deep sensibility of parts beneath the anæsthetic skin, and a comparison of the deep sensibility of healthy muscles as compared with that of atrophied muscles.

A CASE OF PERFORATING TUBERCULOSIS OF SKULL WITH CEREBRAL SYMPTOMS.—Dr. Walter Edmunds reports (*Brain*, April, 1880) the case of a boy, æt. fourteen, who, after an attack of peritonitis, which was thought to be tubercular, developed a cold abscess in the scalp, over the left parietal bone, accompanied by much headache. It contained thick pus, and was twice aspirated. Six months later, numbness of the right arm and hand occurred; four months later, the abscess re-formed, and he had a fit, in which he felt giddy, fell, became unconscious, foamed at the mouth, bit his tongue, urinated involuntarily, had convulsive movements in both legs, with the right arm clinched and drawn up. Slight paresis of the right face and leg, with more marked paresis of the right hand, was found, with normal sensation, normal temperature and reflexes. No visual disturbance nor headache; both optic discs were slightly swollen, their images blurred; veins knotted, with white lines along the vessels. The abscess was laid freely open, and a portion of diseased bone, seven eighths by five eighths of an inch, was removed, comprising the entire thickness of the skull. It had compressed the brain. Under iodoform dressing the case progressed well, but there was some suppuration with loss of substance on the surface of the brain. He had one fit two weeks later, another eight weeks later, with general convulsions, head turned to the right. In about four months he was sufficiently well to get up and walk about. Weakness of the right arm and hand remained, and an opening in the scalp and skull, through which the brain could be seen. It was covered by a silver plate. The inflammation of the optic discs subsided, the sight remaining not quite normal. The opening in the skull was half an inch in front of the fissure of Roland, but as the superficial ulceration extended backward a short distance from the opening, the middle of the ascending frontal and ascending parietal convolutions were affected.

ACUTE OPTIC NEURITIS ASSOCIATED WITH ACUTE MYELITIS.—Sharkey and Lawford (*Ophthal. Soc. Trans.*, London).—A girl, aged seventeen, previously in good health, rapidly lost her sight, so that in four days she was quite blind, without other prominent symptoms. Well-marked double optic neuritis was found to be present a month afterward. Symptoms of paralysis and loss of sensation in the lower extremities supervened. About three weeks afterward the patient died of symptoms of peritonitis—that

is, sixty-two days from the time vision first failed, and twenty-nine days after the first appearance of symptoms of paralysis. A very careful account of the post-mortem examination is given in detail, showing the brain to be healthy. The spinal cord presented the appearance of acute myelitis of the lower cervical and the upper lumbar regions. The optic tract and nerves, along with the discs and retinæ, were accompanied by all the evidences of intense inflammatory change.

It is pointed out that the interest in this case lies in the association of an acute optic neuritis with acute inflammation of the spinal cord. There is probably some relation between the two, although the one does not depend directly on the other. In this case the optic neuritis appeared a month before the spinal symptoms. Post-mortem examination showed that the spinal cord between the lower cervical and lumbar regions was healthy, so that the centres of disease must have originated independently one of the other. The same may be probably asserted with regard to the optic nerves. Other cases have been published by Clifford, Allbut, Seguin, Noyes, Steffan, and Erb, in which spinal symptoms were associated with changes in the optic discs. Chilson has recorded (*Arch. Ophthal.*, 1882, No. 2) a somewhat similar case, but without post-mortem examination, and Dreschfield has published (*Lancet*, 1882) two cases, each with an autopsy, of acute cord disease accompanied by optic neuritis. These cases, moreover, prove that the occurrence of double optic neuritis in association with nervous disturbance is not of necessity due to cerebral disease.—A. Hughes Bennett in *Brain*, April, 1885.

OCULAR AND TRIGEMINAL AFFECTIONS IN LOCOMOTOR ATAXIA.
—M. Galeowski states (*La Recueil d'Ophthalmologie*, 1884) that in locomotor ataxia visual acuteness is nearly always unequal in the two eyes. Patients may be unable longer to see green and red. On the other hand, reading at short distance is possible for a long time, while acuity of vision for distant objects is much diminished. M. Darier has shown that a much stronger electric current is required to produce manifestations of light in the beginning of ataxia than in toxic amblyopia. In the branches of the fifth pair which border upon the eye, anæsthesia and sometimes hyperæsthesia are observed. The spots where anæsthesia is present rarely are acknowledged by the patient, but to be discovered must be sought for with care. Sometimes patients complain of a feeling of heaviness in the periorbital region and in the face, can no longer feel the contraction of the muscles of this region, and frequently use the hand to assist the motion of the part. Hyperæsthesia is manifested by neuralgia or by lancinating pains similar to those experienced in the lower limbs. Excavation of the optic papilla, which resembles the changes due to glaucoma, accompanies these manifestations of pain.—*Amer. Jour. Med. Sci.*, April, 1885.

W. R. BIRDSALL, M.D.